or a mean excess percent BMI loss (EBL) of 7.4 kg/m^2. At 1 year, the mean reduction in BMI was 11.1 [EBL of 33.6 kg/m^2]. At 2 years, the mean reduction in BMI was 13.29 [EBL of 41.5 kg/m^2]. Correlation between pre-operative weight loss versus weight lost at 1 and 2 years was performed. At 1 year & 2 years post-operatively, the Spearman Rank Correlation was 0.154 [p = 0.208] and 0.069 [p = 0.573] respectively (no statistical significant correlation).
Conclusion: In this study, pre-operative dietary weight loss does not correlate with better outcomes following laparoscopic adjustable gastric banding.

1046: HOW DOES A NORTHERN TRUST WITH UNIQUE GEOGRAPHICAL CHALLENGES COMPARE WITH SCOTTISH NATIONAL DATA FOR ALL CANCERS IN KEEPING TERMINALLY ILL UPPER GI CANCER PATIENTS OUT OF HOSPITAL – TO DIE AT HOME?

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Aim: To study end of life care for Upper GI cancer patients diagnosed within geographically diverse northern NHS Highland.
Methods: Four national databases were searched using ICD10 codes for Upper GI cancer for years 2005-2010. For patients diagnosed in this region, place of death (home, hospital, hospice or 'other institution') was recorded and compared with Scottish national data for all cancers.
Results: 978 Upper GI cancer patients were diagnosed within the study period. 298 were excluded as place of death was unknown. Of the remaining 680 patients 237 (34.9%) died at home, 295 (43.4%) died in hospital, 96 (14.1%) died in hospice and 49 (7.2%) died in another institution. Of 75522 cancer deaths in Scotland between 2004-2008 equivalent percentages were 24.3% (home), 51.9% (hospital), 17.6% (hospice) and 6.2% ('other'). Highly significant differences between NHS Highland and national data were found in both 'at home' and 'in hospital' deaths ($p<0.0001$).
Conclusions: Over half of cancer patients in Scotland die in hospital and a quarter die at home. In our study group, fewer patients die in hospital with over one third dying at home. Despite Highland geographical challenges, ability to deliver end of life care for Upper GI cancer patients is uncompromised.

1155: ONE-STOP CHOLECYSTECTOMY CLINIC: A WAY FORWARD FOR THE FUTURE?

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Objective: To assess whether a 'one stop cholecystectomy clinic' had an impact on the waiting time, pre-operative visits and admissions for patients with gallbladder diseases and thus improved their 18 week pathway.
Patients and Method: A retrospective observational study of patients attending the 'one stop cholecystectomy clinic'(Group A) and the traditional routine clinics (Group B)for patients with gallbladder diseases during 2010 was completed. Patients were preassessed & wait listed for surgery. Primary outcome measured was the waiting time, secondary outcome measured were the pre- operative visits & the emergency hospital admissions whilst awaiting surgery.
Results: Study included 129 patients with a mean age of 49 (SD ±16) years & female to male ratio of 101:28.Of the 129, 59 (46%) belonged to Group A had a waiting time of 7.3* (95% CI 6.2 - 8.5) weeks compared to 16.6 (95% CI 14.0 - 19.2) weeks for the 70 (54%) belonging to Group B(p-value <0.001). One unnecessary hospital visit for pre-assessment was avoided in all Group A compared to Group B patients and 9 (15%) Group A patients needed emergency admission compared to 19 (27%) Group B patients meaning significant cost implications.
Conclusion: One-stop cholecystectomy clinic achieves improved patient journey through reduction in emergency admissions, waiting times and unnecessary hospital visits.

1185: SHOULD CT COLONOSCOPY REPLACE FLEXIBLE SIGMOIDOSCOPY?

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Aims: It is recommended that all patients undergoing barium enema have a flexible sigmoidoscopy (FS) to exclude disease distal to the rectosigmoid junction. With the introduction of CT colonoscopy (CTC) is sigmoidoscopy still required for the investigation of suspected colorectal cancer (CRC).
Methods: The findings of CTC in 520 consecutive patients were reviewed by a GI radiologist blinded to the findings at FS. Patients with not adequate bowel preparation for FS, colonoscopy, polypectomy, abnormal MRI or CTC as first line investigation, more than six months period between CTC and FS were excluded. Statistical analyses were performed with Chi-Squared and Fisher test.
Results: 306 patients were excluded. In 188(88%) patients there was concordance between the findings on FS and CTC. Sensitivity and specificity of FS was 74% and 99% respectively ($p<0.001$)[ppv- 0.93, npv-0.94].FS did not identify 6 cancers when CTC missed only 2 malignant pathologies (classified as inadequate picture due to collapse colon, further investigation has been advised). We could identify statistically significant ($p<0.05$) dependence between bowel symptoms like PR bleeding and iron deficiency anaemia and diagnosis of bowel cancer in patients undergo FS.
Conclusions: A negative CTC excludes the presence of colorectal cancer.

1208: ANAEMIA AND BARIATRIC SURGERY: A DOUBLE WHAMMY

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Background: As bariatric surgery rates continue to climb, anaemia will become an increasing concern. We assessed the prevalence of anaemia and length of hospital stay in patients undergoing bariatric surgery.
Methods: Prospective data (anaemia [Haemoglobin <12 g/dL], haematinics and length of hospital stay) was analysed on 400 hundred patients undergoing elective laparoscopic bariatric surgery. Results were compared to a prospective database of 1530 patients undergoing elective general surgery as a baseline.
Results: Fifty-seven patients (14%) were anaemic pre-operatively. Median MCV (fL) and overall median Ferritin (μg/L) was lower in anaemic patients (83 vs. 86, p=0.001) and (28 vs. 61, $p<0.0001$) respectively. Compared to elective general surgery patients, prevalence of anaemia was similar (14% vs. 16%) but absolute iron deficiency was more common in those undergoing bariatric surgery; microcytosis $p<0.0001$, Ferritin <30 $p<0.0001$. Mean length of stay (days) was increased in the anaemic compared to in the non-anaemic group (2.7 vs. 1.9). Interestingly, patients who were anaemic immediately post-operatively, also had an increased length of stay (2.7 vs. 1.9), $p<0.05$.
Conclusion: Absolute iron deficiency was more common in patients undergoing bariatric surgery. In bariatric patients with anaemia there was an overall increased length of hospital stay, suggesting a role in pre-optimisation.

UROLOGY

0016: MANAGEMENT OF ACUTE EPIDIDYMO-ORCHITIS: SHOULD WE CHANGE OUR PRACTICE?

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Aim: The latest antibiotic guideline for epididymo-orchitis from the British Association of Sexual Health and HIV was released in June 2010. We reviewed the management of patients presenting with epididymo-orchitis over a 2 year period to see if the new guideline should be incorporated locally.
Method: Data was collected retrospectively looking at all patients presenting to hospital with a diagnosis of epididymo-orchitis from July 2008 to August 2010. Information collected included; patient age; admission date; mid-stream urine for routine culture and/or Chlamydia PCR; scrotal ultrasound findings; treatment and re-presentation to hospital.
Results: 66 patients were identified. The mean age was 47.29 years with twenty patients being below 35 years. Antibiotic treatment regimes used included Gentamicin and Ciprofloxacin (15.2% of cases), Ciprofloxacin alone (48.5%) and Doxycycline +/- Ciprofloxacin (15.2%). 9 patients had operative intervention. 3 cases were untreated. 3 patients re-presented to hospital with unresolved symptoms or complications.
Conclusion: Our current antibiotic policy seems to be successful as indicated by the few re-presentations and complications. Similar regimes are in use region wide. The 2010 guideline would suggest changing practice. However,